SHINE Program at HESSCO (781) 784-4944

Medicare Drug Plan Pre-Enrollment Information

Print Name: _____ **Phone:**_____ **Date of Birth:**_____

Address: _____
Street City Zip Code

Medicare #*:_____ **Effective Date**of Medicare A** _____**B:**_____
*As it appears on your Medicare card **As it appears on your Medicare card - Month & Year

Email address :_____ **Married**____ **Widowed** ___ **Single** ____

Are you enrolled in any of the following insurance plans, please check if yes:

Blue Cross/Blue Shield Medex Bronze: _____
Blue Cross/Blue Shield Medex Sapphire:____
Blue Cross/Blue Shield Medex Core: _____

Fallon Supplement 1: _____
Fallon Supplement 1A:____
Fallon Core: _____

Harvard Pilgrim Supplement 1: _____
Harvard Pilgrim Supplement 1A:____
Harvard Pilgrim Core: _____

Health New England Supplement 1: _____
Health New England Supplement 1A: _____
Health New England Core: _____

Humana Supplement 1: _____
Humana Supplement 1A: ____
Humana Core: _____

Tufts Supplement 1: _____
Tufts Supplement 1A: _____
Tufts Core: _____

United /AARP Supplement 1: _____
United /AARP Supplement 1A: _____
United/AARP Core: _____

VA Health Plan: _____ TRICARE: _____
Other – Name of plan/company: _____

Are you in an employer retiree plan? Yes _____ No_____ If yes, please provide information:

Name of Plan: _____ Does the plan provide prescription coverage? Yes ____ No ____

Do you have a Medicare Part D Drug plan? Yes___ No___ If yes, name of plan_____

Do you have a Medicare Advantage (HMO or PPO) plan? Yes___ No___ Plan: _____

Are you enrolled in Prescription Advantage? Yes _____ No _____ No, but I have applied _____

Do you receive help with Medicare prescription drug plan costs? (LIS/Extra Help)? Yes ____ No ____

Are you enrolled in MassHealth? Yes _____ No _____

Note: There are benefit programs that might help with your health care costs. If you want us to check your eligibility, tell us your GROSS monthly income (you & spouse combined): $_____

PLEASE LIST YOUR PRESCRIPTION MEDICATIONS ONLY ON THE BACK SIDE OF THIS FORM

For Office Use Only
MyMedicare Acct. Established on: _____
by: Client: _____ Shine: _____
U: _____
P:_____
General Search will be done: _____
Counselor: _____

For Office Use
Rec'd._____

What pharmacy do you use?_____

Pharmacy choice can impact your costs. Would you change your pharmacy to save money? Yes _____ No _____

If yes, **NAME SPECIFIC PHARMACIES** you would use: _____

I only want to use mail order with my drug plan: Yes_____ No_____

Drug Name Example: Metoprolol Succinate Novolog FlexPen * **AS IT APPEARS ON THE BOTTLE:** IF YOU TAKE GENERIC LIST THE GENERIC NAME * **DO NOT LIST** VITAMINS, ASPIRIN, OR OTHER OVER THE COUNTER NON PRESCRIPTION ITEMS	**Drug Strength & Dosage** Example: 50 Mg. – one per day 8 Pens per month * **WRITE TABLET or CAPSULE, VIALS, TUBES, BOTTLES (with the size of bottle)** * **LIST MONTHLY QUANTITIES** * **DO NOT WRITE "AS NEEDED" AS A QUANTITY - ESTIMATE HOW MANY AND HOW OFTEN?**
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	
13.	
14.	

IF YOU HAVE AN APPOINTMENT WITH A SHINE COUNSELOR, PLEASE BRING THIS COMPLETED FORM ALONG WITH YOUR MEDICARE CARD TO YOUR APPOINTMENT

If not, please mail this completed form to:
HESSCO Elder Services
One Merchant Street, Sharon, MA 02067
Attn: SHINE Office